

MURTHA CULLINA LLP

A T T O R N E Y S A T L A W

ELIZABETH NEUWIRTH
(203) 772-7742
ENEUWIRTH@MURTHALAW.COM

WHITNEY GROVE SQUARE
TWO WHITNEY AVENUE, P.O. BOX 704
NEW HAVEN, CONNECTICUT 06503-0704

2005 MAR 4 PM 3:44
TELEPHONE (203) 772-7700
FACSIMILE (203) 772-7723
www.murthalaw.com

CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

March 4, 2005

HAND DELIVERED

Commissioner Cristine A. Vogel
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

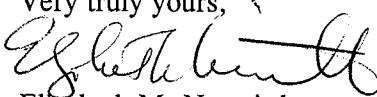
Re: Letter of Intent Filing by Continental Connecticut Lithotripsy, LLC

Dear Commissioner Vogel:

We enclose a Letter of Intent ("LOI") to file for a Certificate of Need with respect to the purchase of a transportable lithotripter. Our client, Continental Connecticut Lithotripsy, LLC respectfully requests that the Office of Health Care Access expedite processing of the Letter of Intent so that the applicant may move quickly to the Certificate of Need application process.

The current lithotripsy provider for eight hospitals owns Swiss manufactured equipment which uses disposable electrodes. Due to the bankruptcy of the manufacturer, electrodes required for treatment have become very difficult to obtain and are likely to become unavailable. Existing supplies will be exhausted within twelve weeks. The current provider cannot raise the necessary capital to purchase a new lithotripter, and will have to cease providing lithotripsy treatment when it can no longer obtain the needed electrodes. This would leave a service gap for patients suffering from renal and urinary stone disease who are treated as outpatients at area hospitals. The applicant is ready and able to acquire new equipment and begin operations for this population as soon as it has approval to do so, and plans to contract with the hospitals served by the current provider in order to provide continuity of service to these patients.

If I can offer any information that would be helpful in processing this LOI, please do not hesitate to call me.

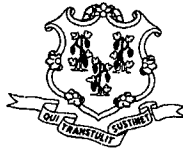
Very truly yours, 
Elizabeth M. Neuwirth

Enclosures

B O S T O N

H A R T F O R D

N E W H A V E N



RECEIVED

2005 MAR -4 PM 3:44

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Continental Connecticut Lithotripsy, LLC	
Doing Business As	Same	
Name of Parent Corporation	Applicant's Member is Continental Medical Services, LLC	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	2014 Litho Place Fayetteville, NC 28304	
Applicant type (e.g., profit/non-profit)	P	
Contact person, including title or position	Dan A. Myers, M.D. Manager	
Contact person's street mailing address	2014 Litho Place Fayetteville, NC 28304	

Contact person's phone #, fax # and
e-mail address

877 906-0826 (p)
910 223 0600 (f)
danohsd@earthlink.net

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Purchase of equipment necessary to operate a transportable lithotripsy service.

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

S New (F, S, Fnc)

☐ Replacement

☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc)

☐ Relocation

☐ Service Termination

☐ Bed Addition

☐ Bed Reduction

☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than \$ 1,000,000

X Equipment Acquisition greater than \$ 400,000

X New

☐ Replacement

☐ Major Medical

☐ Imaging

☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$1,000,000

c. Location of proposal (Town including street address):

N/A --Mobile equipment will be transported to service sites.

d. List all the municipalities this project is intended to serve: throughout Connecticut, including Southington, Meriden, New Britain, Rockville, Bridgeport, Waterbury, Norwich and Willimantic

- e. Estimated starting date for the project: September 1, 2005
- f. Type of project: 23, 24 (Fill in the appropriate number(s) from page 7 of this form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Capital Expenditure: \$ 572,400
- b. Please provide the following breakdown as appropriate:

Construction/Renovations	\$ N/A
Medical Equipment (Purchase)	475,000 *
Imaging Equipment (Purchase)	N/A
Non-Medical Equipment (Purchase)	65,000
Sales Tax	32,400
Delivery & Installation	0
Total Capital Expenditure	\$ 572,400
Fair Market Value of Leased Equipment	N/A
Total Capital Cost	\$ 572,400

* includes imaging features

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
Lithotripter	Storz	SLX-T	1	\$475,000

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

- ☐ Applicant's Equity
 ☐ Lease Financing
 ☒ Conventional Loan
- ☐ Charitable Contributions
 ☐ CHEFA Financing
 ☐ Grant Funding
- ☐ Funded Depreciation
 ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

RESPONSES ATTACHED ON SEPARATE SHEET

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

- Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
- What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
- Who is the current population served and who is the target population to be served?
- Identify any unmet need and how this project will fulfill that need.
- Are there any similar existing service providers in the proposed geographic area?
- What is the effect of this project on the health care delivery system in the State of Connecticut?
- Who will be responsible for providing the service?

8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following:
(Please check all that apply)

- ☐ This request is for Replacement Equipment.
 - ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
 - ☐ The cost of the equipment is not to exceed \$2,000,000.
 - ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant:
Project Title:

I, _____,
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the
information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to
the best of my knowledge, and that _____ complies with the
appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638,
19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Applicant's Responses to OCHA Questions

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

Applicant does not currently provide services nor does it hold any DPH license. Mobile lithotripsy services are currently being provided by another entity (Connecticut Lithotripsy, LLC) which intends to liquidate and sell its existing equipment outside the State of Connecticut. Connecticut Lithotripsy, LLC currently owns a lithotripter manufactured by a bankrupt Swiss company. As a result, required disposable electrodes for this machine (one electrode is required for the treatment of every two (2) patients) are in short supply and may no longer be available. The existing entity cannot afford to purchase new equipment. Remaining electrode supplies are expected to last for approximately twelve (12) weeks from this date, after which Connecticut Lithotripsy, LLC will likely be unable to provide mobile lithotripsy services to the eight (8) hospitals it now serves in the State. Connecticut Lithotripsy, LLC is working with the Applicant to transition service at these eight (8) hospitals before its electrode supply is exhausted.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?

Applicant plans to purchase a new state-of-the-art lithotripter manufactured by a solvent and reliable company, and the truck necessary to transport it to treatment sites. Applicant expects to contract with the hospitals presently served by Connecticut Lithotripsy, LLC in order to maintain lithotripsy service continuity to their outpatient populations. Applicant does not believe DPH licensure is required.

3. Who is the current population served and who is the target population to be served?

Patients who require extra-corporeal shock wave lithotripsy to treat renal and urinary stone disease are the target population. Applicant plans to treat hospital outpatients at eight (8) hospital sites currently receiving mobile lithotripsy services from the present mobile lithotripsy provider, Connecticut Lithotripsy, LLC before it is forced to cease providing such services.

4. Identify any unmet need and how this project will fulfill that need.

After existing stored disposables are used, current mobile lithotripsy provider will likely be unable to obtain more and will have to cease providing lithotripsy services in the area. Applicant plans to begin operations immediately upon approval of Certificate of Need.

5. Are there any similar existing service providers in the proposed geographic area?

Please see responses above.

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

The project will allow the seamless maintenance of lithotripsy services that would otherwise become unavailable to the target population.

7. Who will be responsible for providing the service?

Applicant, through technicians trained in the operation of lithotripters and working under the supervision of urologists.

8. Who are the payers of this service?

Commercial insurers and Federal health care programs.

03/03/05 16:55 FAX 9102230800
03/03/2005 16:45 FAX 6783548839

SONOREX
KARL STORZ LITHO

→ GREG SMITH

001
002

STORZ
Karl Storz Lithotripsy

Karl Storz
Lithotripsy-America, Inc.

1000 Cobb Place Boulevard
Bldg. 400, Suite 450
Kennesaw, Georgia 30144

Toll Free 800 965 4848
Phone 678 581 7220
Fax 678 354 6843

QUOTATION AND SALES AGREEMENT

This Quotation Supersedes all Previous Quotations

No.: 0506201PA

Phil Galina
Continental Connecticut Lithotripsy, LLC
c/o Continental Medical Services, LLC
2014 Litho Place
Fayetteville, NC 28304
Fax: 910-223-0600

March 3rd, 2005

DESCRIPTION	AMOUNT
STORZ MODULITH® SLX TRANSPORTABLE LITHOTRIPTER [Per Product Specification # 96190US] and Includes: <ul style="list-style-type: none">• OEC Series 9800 Digital Mobile Imaging System• Urological Accessory Kit• Compression Belt• Motorized Pallet Jack• 12 Month Warranty (Refer to Terms and Conditions of Sale, Section 8.0)	
TOTAL PRICE	\$475,000.00*
<p><i>*Does not include cost of Shipping or Applicable Taxes</i></p> <p>TERMS 30% Deposit, 60% due upon Shipment, and remaining 10% due upon customer Acceptance. Freight: FOB Kreuzlingen, Switzerland. All applicable taxes are the responsibility of the customer and will be based on delivery location. If not previously accepted, expiration of this Quotation and Sales Contract is <u>May 3rd, 2005</u>.</p> <p><i>Terms and Conditions of Sale are attached to this Quotation and Sales Contract and are to be considered a part of thereof and are incorporated herein by reference.</i></p>	

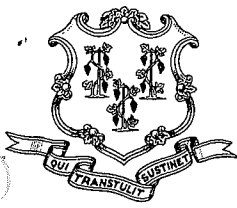
This quotation includes data that shall not be disclosed and shall not be duplicated, used, or disclosed – in whole or in part – for any purpose other than to evaluate this quotation. If however, a contract is awarded to this offeror or quoter as a result of – or in connection with – the submission of this data, the recipient shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting contract. This restriction does not limit the recipient's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction is contained in the entire package herein. By signing below, Customer agrees to pay the total amount due under this Quotation and Sales Contract and further agrees to all terms and conditions set forth in the attached Terms and Conditions of Sale.

Customer:

By: _____
Title: _____
Date: _____

Karl Storz Lithotripsy - America, Inc.:

By: Greg Smith
Title: Area Manager
Date: March 3rd, 2005



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL
COMMISSIONER

April 13, 2005

Dan A. Myers, M.D.
Manager
Continental Connecticut Lithotripsy, LLC
2014 Litho Place
Fayetteville, NC 28304

RE: Certificate of Need Determination; Report Number 05-30448-DTR
Continental Connecticut Lithotripsy, LLC and Connecticut Lithotripsy, LLC
Change of Ownership of Lithotripsy Service and Acquisition of Major Medical
Equipment

Dear Dr. Myers:

On March 4, 2005, the Office of Health Care Access ("OHCA") received your CON Determination request on behalf of Continental Connecticut Lithotripsy, LLC for change of ownership of lithotripsy service and acquisition of major medical equipment, at a total capital expenditure of \$572,400.

OHCA has reviewed the information contained in the request and makes the following findings:

1. Continental Connecticut Lithotripsy, LLC ("Petitioner") is a lithotripsy service vendor located at 2014 Litho Place, Fayetteville, NC 28304.
2. The Petitioner does not currently provide lithotripsy services in Connecticut, nor does it hold any license issued by Connecticut Department of Public Health.
3. The Petitioner proposes to establish lithotripsy service in Connecticut at hospitals that currently have a contractual arrangement for lithotripsy services with Connecticut Lithotripsy, LLC ("CT Litho").
4. CT Litho was deemed to be a health care facility for purposes of providing lithotripsy services in Connecticut.
5. CT Litho currently provides lithotripsy service at eight hospitals in Connecticut. CT Litho is planning to transfer the lithotripsy service at these eight hospitals to the Petitioner.

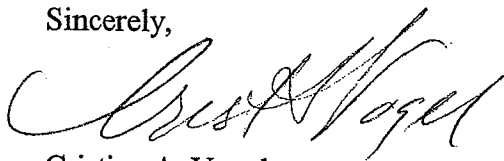
6. The total capital expenditure of the proposal is \$572,400. This includes \$475,000 for the lithotripsy machine, \$65,000 for non-medical equipment and \$32,400 for sales tax.
7. Pursuant to Section 19a-630 of the Connecticut General Statutes ("C.G.S."), Health care facility or institution" means any facility or institution engaged primarily in providing services for the preventions, diagnosis or treatment of human health conditions."
8. Pursuant to Section 19a-638 C.G.S., the Office of Health Care Access ("OHCA") requires a CON whenever a health care facility or institution proposes a change in ownership.
9. Pursuant to Section 19a-639, C.G.S., OHCA requires a CON whenever any health care facility or institution proposes a capital expenditure exceeding one million dollars, the acquisition of major medical equipment having a cost exceeding four hundred thousand dollars, including the leasing of equipment or a facility, or whenever any person proposes a capital expenditure to acquire imaging equipment having a cost exceeding four hundred thousand dollars, including the leasing of such equipment.

Based on the above findings, OHCA has determined that Continental Connecticut Lithotripsy, LLC and Connecticut Lithotripsy, LLC are considered health care facilities for certificate of need purposes. Further, the request for the change of ownership of lithotripsy service and acquisition of major medical equipment of over \$400,000, therefore, pursuant to Sections 19a-638 and 19a-639 C.G.S. a certificate of need is required for your proposal.

Please be advised that your CON Determination is considered to be your Letter of Intent and as such you may file your CON Application between May 6, 2005 and July 5, 2005. A CON application will be mailed to your attention under a separate cover.

If you have any questions regarding the above, please contact Steven Lazarus, Associate Health Care Analyst at (860) 418-7012.

Sincerely,



Cristine A. Vogel
Commissioner

CAV:sl

Copy: Sandra C. Bauer, Division of Community Based Regulation, DPH